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ABSTRACT

The problem is stated as follows: university campuses must find a reasonable, responsible, and financially defensive provision for mental health services. The first part of the paper concerns itself with: (1) defining mental health; (2) defending the appropriateness of mental health services as a necessary part of an educational institution; (3) exposing the need for such services; (4) discussing its placement within the organizational structure of colleges and universities; and (5) elaborating its responsibilities to individual students and to the college community as a whole. The second part of the paper presents the findings of the Texas Technological Psychiatric Survey. The responses of 73 universities to a psychiatric questionnaire were tabulated so as to provide information on numerous aspects of existing university mental health services including staffing, referrals, funding, extent, and effectiveness. Based on: (1) this survey; (2) a review of pertinent professional literature; (3) authoritative recommendations; and (4) a review of organizational and financial realities of university campuses, conclusions are drawn and resulting recommendations offered. (TL)

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UNIVERSITY PROVISIONS

FOR

PSYCHIATRIC SERVICES

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TEXAS TECH UNIVERSITY LUBBOCK, TEXAS

UNIVERSITY PROVISIONS FOR PSYCHIATRIC SERVICES

While one may discuss and debate the optimum provisions for mental health services on a university campus, it is unlikely that extremes in either direction could be justified. Providing all types of services on an unlimited basis at no cost to students would be financially prohibitive, even if such a philosophy were adopted by an institution and adequate professional staff obtained. On the other hand, to provide no services of any type for students, ignores or denies the minimum responsibility expected of an institution by students, parents, and even taxpayers of the state. The problem for an institution, then, becomes one of determining where, between these two extremes, may be found a reasonable, responsible, and financially defensive provision for nonacademic services to students.

Among student personnel services which are typically provided, some are not as difficult to defend or finance as others. As long as there is a reasonable level of competency and financial expenditure, few serious questions are raised regarding the areas which provide student personnel records, student activities, financial aids, career placement, and the administration of student conduct. Rather clear cut interpretation is found in the areas of admissions, registration, orientation, and academic advisement, which are seen as part of the academic enterprise. The opposite may be true of a student health service which in Texas, for example, is prohibited the use of state funds by an act of the Fifty-sixth Texas Legislature and must be financed entirely from student fees. Falling somewhere in between those things which must be provided from state funds and those which may not utilize any state funds are a number of activities which have both academic and individual student relationships. In this group would be found student publications, campus radio and television stations, intramural programs, and perhaps international student services.

Clinics, centers, and services which have an objective of providing training or internship type experiences for undergraduate and graduate students, and which utilize the student population as clients, form another group in this area. Included here would be the Psychological Clinic, Speech and Hearing Clinic, and Rehabilitation Service. A final group of services may be identified as those with an objective of helping the individual student with personal problems, although they may or may not be related to the student's academic activity. The Counseling Center is the primary example here, but Reading and Study Skills Clinics, Psychiatric Services, Residence Hall Counselors, and Marriage Counseling Bureaus would also be identified with this group. Funding these latter services can be one of the more difficult problems in an institution's budgeting process.

Mental Health in the University Setting.

To separate an individual's mental health from his total functioning is impossible. Essentially, one's health--mental and physical--is a very vital part of his performance. This, it seems, has much significance for the planning of higher education. Institutions of higher education cannot concentrate totally on the academic preparation of their students. The meaningfulness of education in relation to the total individual must be a major consideration.

The services offered by any institution of higher education should be related to its goals and to the goals of higher education generally. Robert

Maynard Hutchins, former chancellor of the University of Chicago, once remarked that the function of the university was not to teach but rather to provide an atmosphere where learning could take place. (12) Very broadly, the goal of education has been defined by Gardner as follows:

> Education in the formal sense is only a part of society's larger task of abetting the individual's intellectual emotional, and moral growth. What we must reach for is a perpetual self-discovery, perpetual reshaping to realize one's best self, to be the person one could be. (6)

If such a statement were accepted by an institution as its educational goal, then it would seem that a dynamic student personnel program, including mental health services, would need to be established as well as an excellent academic program.

Several authors have specified certain objectives for the student personnel program within institutions of higher education. Shaffer and Martinson provide a typical list of the objectives of student personnel work in the college setting:

1. To assist in providing a campus climate in student residences and campus affairs which is conducive to academic achievement while providing maximum intellectual stimulation.
2. To provide those services which will assist in the self-development of each student and promote the understanding of his own purposes for being in college.
3. To provide through student government and other activities an opportunity to practice democratic living with both its rights and responsibilities and to learn to work effectively with others.
4. To provide the opportunity for faculty-student contacts outside the classroom as a means of encouraging respect for learning and an understanding of the approach to life's problems.
5. To provide an opportunity for every worthy student to complete his education--providing financial assistance, when necessary, in the form of scholarships, loans, and employment.
6. To help each student develop a sense of individual responsibility and self-discipline.
7. To interpret university objectives, policies, rules, and administration to students, faculty, alumni, and citizens in general; and to communicate student attitudes, opinions, and activities to the faculty and general public.
8. To help create an atmosphere of high morale and loyalty towards the institution. (15)

In looking at each of these objectives, it would seem that a college

or university mental health service could contribute to the achievement of many of them. Assuming that these are desirable objectives, then, one might conclude that the mental health service does belong in the college and university setting.

Defining Mental Health.

There exists no easy, structured definition of mental health. In fact, it seems that in the past more emphasis has been placed on defining mental illness than on mental health and misconceptions still exist about what mental health really is. The vagueness prevalent in describing the term "mental health" is illustrated by the following statement:

> Mental health does not imply the absence of conflicts and emotional problems; nor is it simply a general state of personal contentment, satisfaction, and peace of mind. (11)

A very acceptable description of mental health is given by Marie Johoda in her 1958 report to the Joint Commission on Mental Illness and Health. She listed six approaches which could be utilized in describing mental health as follows:

1. Attitudes of an individual toward his own self.
2. Growth, development, or self-actualization.
3. Integration.
4. Autonomy.
5. Perception of reality.
6. Environmental mastery. (16)

History of College Psychiatry.

Reifler and Liptzin (13) credit Dr. Stuart Paton with developing the first formal mental health program in a student health service at Princeton in 1910. According to Farnsworth (4), Dr. Smiley Blanton was helping students with personal problems at the University of Wisconsin as early as 1914. In 1920, Dr. Karl Menninger developed a mental hygiene course and a counseling system at Washburn College, Topeka, while Dr. Harry Kerns was appointed to what was perhaps the first full-time position as campus psychiatrist at the

U.S. Military Academy at West Point that same year. Dartmouth (1921), Vassar (1923), and Yale (1925) soon developed psychiatric programs in their health services. In 1927, at a meeting of "college mental hygienists" sponsored by the Commonwealth Fund, 21 schools were represented. Over the years increasing numbers of institutions of higher learning have made provisions for psychiatric services on the campus. (10)

The Need for Mental Health Services.

Reports indicate that colleges and universities which have a well-established and well-staffed mental health clinic estimate use ranging from 5% to 15% of the student body being seen in any one year. According to Reifler (12), one of the best staffed services is at Yale, where they are currently seeing about 10% of the student body each year. Whittington (18) states: "At most universities, five per cent, or more, of the student body are seen by the psychiatric clinic at the university in any one year."

There have been a number of quantitative studies on the prevalence of psychiatric disorders among the college student population. Based upon these, the figure of 10% has subsequently been used as a convenient figure by many writers when discussing college mental health needs. (13) It should be understood that not all students in this 10% are seriously disturbed. Many present problems of general adjustment which are not really clinical in nature. Farnsworth (5) estimated that any college or university at any time can expect that about two students in every 1,000 will have a psychotic illness each year.

In the discussion of the acutely disturbed, it seems worth noting here that among college students, suicide is becoming an increasingly greater problem. Whitely (17) states that the rate of suicide in a college population is 1.5 per 10,000 students per year which is 50 per cent higher than for the general population.

Another increasing problem on college and university campuses is student use of drugs, especially hallucinogenic drugs. While this does not seem to be a problem solely within the realm of the mental health service, the relationship between drug use and personal problems of the individual user is well-established.

Placement of Mental Health Services.

The placement of mental health services, within the organizational structure of colleges and universities varies widely. Some exist within the student health service, while others operate as a separate unit under student personnel services. These seem to be the two most common arrangements. On some campuses, however, mental health services may exist both in the student health service as well as in a separate counseling service where the services may be provided by psychiatrists, psychologists, or psychiatric social workers. Probably, the ideal situation would be to have a mental health team with members representing each of these professions available for service to the entire campus community.

From the literature, some of the ideas which have been expressed supportive of maintaining a separate mental health clinic are

1. removal from the "hospital environment," thus probably encouraging more students to seek help;
2. confidentiality of information might be more assured; and
3. closer ties could be maintained with the testing center.

Farnsworth is very emphatic in his belief that the mental health service should be a part of the student health service. He states:

> A psychiatric service should always be part of the college or university health service; the chief should report to the health service director while at the same time maintaining a considerable amount of autonomy. This is necessary to prevent any breaches of confidence...
>
> Psychologists and social workers form an integral part of the psychiatric service. In most health services their work with students is functionally the same as the psychiatrists' although psychiatric supervision or consultation should always be readily available. (3)

Farnsworth does concede, though, that joint appointments of staff members to the health service and to a counseling service might occasionally work. He stresses that the most important factor is that there be free channels of communication between the mental health coordinator and all other persons within the college concerned with the emotional maturity of the student. (3)

One of the major advantages of organizing the mental health service within the student health service, as expressed throughout the literature, is that of coordination of services. It does seem that the comprehensiveness of the service could be increased by close coordination of the program within one location.

Many advantages are apparent, also, when the mental health service occupies an off-campus location. Such is the location of the College Center in Boston which recently was given the Silver Award by the American Psychiatric Association for its program to meet the mental health needs of 58,000 students, faculty, and staff members in 21 colleges and universities in the Boston area.

> The College Center in Boston began operation in September, 1966, and is said to be the first of its type. Housed in a modern office building in the heart of the city, the center is within walking distance of several colleges and readily accessible by public transportation and by automobile. The off-campus location offers anonymity for the patients, and the attractive and contemporary setting is felt to be unlike that of a hospital or the usual mental health center. (8)

Functions of the Mental Health Service.

The responsibilities of the psychiatrist and other members of the mental health team are basically two-fold: treatment and therapy of the individual student, and service to the college community as a whole. Many who are presently responsible for mental health services stress the importance of freeing the psychiatrist, to a great extent, from time commitments to individual therapy. They place strong emphasis on mental health education which includes the areas of public health and preventive psychiatry.

Services to the Individual Student. Diagnostic interviews should be provided for all students who come for help, whether they are self-referred or sent by a member of the faculty or administration. Short-term therapy should be provided when the psychiatrist (or other member of the mental health team) feels that the student could benefit from this type of help. Otherwise, appropriate referrals should be made to other resources if necessary.

Emergency treatment and crisis consultation should be available to students. As Farnsworth (2) states: "Emergency treatment is probably the most dramatic function a university psychiatrist performs." This depends, of course, on the alertness of many other people, residence hall counselors, faculty, or other students, in being aware of existing problems.

Mental Health Education. Much of the literature concerning college mental health education centers around discussions of public health and preventive psychiatry. Public health is defined as the scientific diagnosis and treatment of the community. (9) The community, not the individual, is the patient. According to Reifler (14),since the first mental health program in a student health center was established in 1910, college psychiatry has been focused as much upon the treatment of the community as upon those few individuals who have developed psychiatric problems.

Whittington (18) defines preventive psychiatry as "the prevention of recognizable mental disorder." In order for preventive psychiatry to operate and be effective on a college campus, all members of the college community must be involved. To bring about this involvement, the mental health team must educate and work closely with the faculty, administration, and student body through various programs of public health. Alex Braiman (1) states: "One of the most important roles of the college psychiatrist . . . is to educate those who come into contact with students to recognize signs of illness."

The mental health team can provide direction to many college, faculty, staff, and personnel workers who have close association with students. Whittington (18) expresses particular concern in the area of the residence hall counselors: "In the university setting, residence hall counseling has become an increasingly refined procedure and has some application in the field of case-finding and secondary prevention, as well as being a pervasive influence in helping maintain an emotionally healthy climate." At the University of North Carolina, considerable research has been done in regard to the use of their mental health services. Contrary to the experience of almost all other college health services, they found a consistently lower usage of the facility by freshmen and sophomores. One explanation for this was their extensive academic advising program for freshmen and sophomores. Another possible explanation is the strong advisor program in the residence halls in which the majority of freshmen and sophomores live. Their preliminary explorations showed a higher psychiatric usage rate for those students living off-campus. One of their reports (14) points out: "Three years ago, in fact, we found such an unusually high proportion of serious illness among freshmen males who lived off campus that the administration decided to require all freshmen to live in the residence hall."

The classroom is another important area where unusual behavior can be noted and early intervention possible. This involves mental health education programs for faculty so that they can be aware of certain problems and behavioral trends. The professional staff members of the mental health service can provide the leadership in this area and also provide consultative services to other members of the university staff.

Other Mental Health Services. Mental health classes for students should be an important function of the mental health program. The professional staff should provide direction in this area. Along this line, but more informal, would be discussion groups with students. Whittington (18) states: "The most effective approach would be to apply the crisis model to mental

health education." When some crisis occurs concerning mental health in regard to the behavior of a student, it would be helpful for mental health consultants to be available and discuss the immediate situation with students. Emphasis would be placed on the meanings and implications the behavior has on other students. Publishing reports that are pertinent to the problems and needs of the students is still another means of educating the campus community, but is not usually listed as one of highest priority.

Crucial to the development and execution of a college mental health program is the continuing evaluation of the program. The college population, with its relative homogeneity of successive classes, provides an ideal model for research. Mental health programs and services should not be static, but reflect the changing campus environment and student needs. The judicious expenditure of funds for psychiatric services requires that those responsible for the program utilize continual evaluation as a part of program planning for the future.

TEXAS TECH UNIVERSITY PSYCHIATRIC SURVEY

Purpose of Survey.

For several years, Texas Tech University has been considering extending its student programs to include psychiatric services. The literature, however, has very little in the way of definitive information regarding either existing conditions of psychiatric services on campuses or specific standards recommended for such services. They do agree that such services are needed and that all colleges and universities should strive to provide them in adequate proportion. At present there are available to students on the Texas Tech University campus a counseling center staffed with psychologists, a psychological clinic, and a health center but no psychiatric services, as such. While the criteria are vague, it would seem that Texas Tech with almost 20,000 students has need

for additional services of this type.

Procedures.

A list of all members of the National Association of State Universities and Land Grant Colleges plus larger state colleges and universities in all states who were not NASULGC members resulted in ninety-one universities which were sent psychiatric questionnaires. Eighty-two were returned (90%). Seventy-three of these universities had psychiatric services available on campus and completed the questionnaire. Nine universities stated that they did not employ a psychiatrist and, therefore, could not participate in the survey. The University of Wisconsin at Madison reported having 39 equivalent full-time psychiatrists and 32 psychiatric interns or residents. Because these numbers are extremely high in relation to the other universities reporting, the University of Wisconsin was excluded in averaging the number of psychiatrists and psychiatric interns. The other responses were tabulated with the results based on a total of 73 universities. The universities participating in the survey and a copy of the survey form will be found at the end of this report.

Results.

Psychiatrists on staff.

The average for the 72 universities (excluding the University of Wisconsin) is 1.34 equivalent full-time psychiatrists. The range is from .03 to 10 full-time equivalent psychiatrists employed by the responding universities. Reporting universities indicate:

56 universities (77%) employ at least one part-time psychiatrist.
33 universities (45%) employ at least one full-time psychiatrist.
24 universities (33%) employ two or more part-time psychiatrists.

Psychiatric interns and residents.

There are 21 universities (29%) utilizing psychiatric interns or residents, again excluding the University of Wisconsin. Of those reporting numbers of psychiatric interns or residents (15), the average is 3.33. The range is from 1 to 10.

Hours of psychiatric services available per week.

There were 19 universities (26%) that gave no breakdown of psychiatric services by hours. The following information was given by those who did give some sort of breakdown:

25 universities (46%) had no time allotted to administrative duties.
5 universities (9%) made note of research and teaching time.

No pattern was established, so no attempt will be made to generalize the breakdown of consultation, evaluation, and therapy.

Salaries.

Only 48 universities (66%) gave the 12 month salary of their full-time psychiatrists with an average of $22,596.53. The range is from $16,500 to $30,000 a year. Other salaries were given by the hour, interview, or evaluation, with the following averages:

Evaluation	-	$25.00
Consultation	-	$45.00
Hour	-	$25.00
Interview	-	$27.50

Departmental account from which psychiatrists are budgeted.

The budget source was reported by 63 universities (86%). Of these, psychiatric services are budgeted as follows:

32 universities (51%)	-	100% student fees
16 universities (25%)	-	100% state appropriations
3 universities (5%)	-	100% tuition
2 universities (3%)	-	100% university general fund
10 universities (15%)	-	Combination of sources (grants, fees, etc.)

Departmental assignment of psychiatrists.

The budgeting and assigning of the psychiatrists were reported as follows:

51 universities (70%) stated that their psychiatrist is budgeted on the university health service account (some via Student Affairs), and is also assigned to the health service.

4 universities (5%) budget their psychiatrist on the dual account of the Health Service and Counseling Center, and he operates in both areas.

5 universities (7%) budget their psychiatrist on the Counseling

Center account and assign him to this department.
3 universities (4%) stated that the psychiatrist is budgeted from the Administration or the Student Affairs Division and is assigned there.
10 universities (14%) budget in whole or in part from the Department of Psychiatry in their medical school. In most cases, the university psychiatrist is assigned a part-time faculty position in this department of the medical school.

Referrals.

For the most part, the universities stated that they will accept referrals for their psychiatric services from nearly any source. Four universities (5%) require referral or screening through the Health Services or Counseling Center, depending upon the psychiatrist's base of operations. Typical responses included the University of Minnesota, which reported that it has 50% self-referral, and the University of Utah report which included the following: self-referral - 45%, Health Center referral - 19%, and referral by friends - 10%.

Therapy limits.

The breakdown of the reporting universities as to the limits for therapy referrals is as follows:

9 universities (12%)	- no therapy
22 universities (30%)	- no limits
12 universities (16%)	- no rigid limits
6 universities (8%)	- "short-term" therapy although no exact limits specified
2 universities (3%)	- limit of one semester/quarter
3 universities (4%)	- limit of two semesters/quarters
18 universities (25%)	- limits ranging from one session to 12 sessions

A somewhat different approach is found at the University of Virginia where there are no limits, but the Student Health Service fee covers the first $100 for therapy charges.

Records.

There were 69 universities that replied as follows concerning records of psychiatric visits:

4 universities (6%)	- no records kept
13 universities (19%)	- part of permanent health record
3 universities (4%)	- part of Counseling Center records
1 university (1%)	- part of Mental Health Center records
48 universities (70%)	- separate psychiatric files, usually in a locked file and available only to the staff

Ten universities (14%) reported that a notation is made in the permanent health record of a visit to the psychiatrist and of any drugs prescribed. All universities in this group had separate files for psychiatrists' records and are included in the group listed accounting for the 70%.

Responsibility for psychiatric service.

Of the 73 respondents, 67 universities (92%) reported that the central administration at their university felt that the institution did have a responsiblity to provide psychiatric services. There were 6 universities (8%) that said that the central administration felt it had no responsiblitly in this area, had no clear-cut policy concerning psychiatric responsibility, or had ambivalent feelings toward the psychiatric services. All but one of the individuals surveyed (administrators of the psychiatric programs) felt personally that the institution had a responsibility to provide psychiatric services.

The extent of the psychiatric services desired by the central administration and the individual responsible for the psychiatric services is as follows:

Extent of Service	Central Administration		Individual Responsible for Psychiatric Services	
	Number	Percent	Number	Percent
Evaluation or Diagnosis	38	56	35	49
Consultation & Recommendation	43	63	44	62
Therapy	17	25	25	35
Complete Evaluation & Therapy	12	18	19	27

Note: Totals are in excess of 100% due to multiple types of service by responding institutions.

Those indicating a responsibility for therapy usually clarified this by restricting it to "limited" or "short-term" therapy. This included 10 of the 17 (59%) listed in the administration column, and 18 of the 25 (72%) listed in the individual column in the above chart.

Referral Reluctance.

In regard to the reluctance of students to accept psychiatric referral,

55 respondents (75%) said there was no reluctance, 13 (18%) said that there was reluctance, and 5 (7%) were somewhere in between with qualifying statements such as "not usually," "some do, some don't," or "at times."

Effectiveness of the psychiatric services.

Responses to the effectiveness of the psychiatric services on their campuses were given by 70 universities as follows:

	Number	Percent
Great benefit	41	57%
Some benefit	20	29%
Little benefit	0	0%
Difficult to evaluate	10	14%

Constructive Suggestions.

The suggestions made by the responding psychiatric service administrator provides a graphic description of their feelings concerning the provisions of psychiatric services on the university campus.

Concerning the psychiatrist's consultation role with other university staff for the purpose of better mental health education, the following comments were made:

> A greater effort to provide indirect services (consultation, mental health education, liaison work, research, and the like) with preventive implication is needed. Program development should seek toward coordinated and comprehensive student services, employing the principles of the community mental health movement.
>
> Increase in staff time to permit conferences with "front line" people on campus to expedite earlier referral, which would greatly enhance our academic "salvage rate."
>
> For the consultant role of the psychiatrist to be better utilized and understood by university staff/faculty.
>
> More money and better input of students, faculty, and administration, i.e. prevention rather than treatment.
>
> Implementing a community mental health orientation, including active consultation with faculty, administration, and residence hall staff.
>
> Better coordination of campus liaison activities, including residence hall programs, working with faculty, et. cetera. Thus far, our work has been with Dean's staffs, predominantly.

More personnel so that we could undertake more programs in mental health education as well as research into student emotional problems.

More preventive (-educational, community) work with heads of residence, faculty, groups of students, etc.

Expansion of preventive services--education, etc.

To become more helpful to campus community. To practice a preventive psychiatry. Should be used more by administration and faculty in terms of consultation. Would be more truly preventive--makes better use of a scarce item (psychiatric manpower).

Greater involvement in University Program Development as a consultant.

More allocation of staff to working more with residence hall, academic and other non-clinical advisors.

Workshops with residence hall staff and other living groups.

More "intramural" preventive involvement with campus.

You are trying too hard to compartmentalize psychiatric care--many, many people on the health team and for that matter, elsewhere give very good psychotherapy. We have two full-time clinical psychologists and a social worker who do more therapy by far than the psychiatrist, but he is the head of the team. Please get a more team approach attitude with the psychiatrist as consultant to other team members and head of the team.

Further increase in services by the Psychiatric Department to the campus community other than direct and definitive therapeutic services to the patient. Our service is relatively new and I feel that this area of contribution from the Psychiatric Department will increase in future years. I would suggest, however, if you are in your early days of planning this service, that you as much as possible, orient the various areas of your campus community to this service so that from the very beginning they would be seeking the kinds of help that should be available.

Campus-wide involvement in consultative way to teachers, administrators, etc. This should be community psychiatry at its best.

Psychiatry be integrated into a comprehensive mental health program.

Concerning the psychiatrist's role with other campus agencies:

Better budget and better coordination with other campus agencies pretending to do the same thing.

More coordination among various groups and departments offering services.

Concerning the psychiatrist's relationship with the counseling center:

More time to work directly with Counseling Service, as means of ensuring better, safer treatment there, and limiting psychiatric consultations to truly psychiatric problems.

Greater control over the clinical psychologists by the psychiatrist.

Concerning the operation of the psychiatric service:

> (1) Increased use of our in-patient service for acutely disturbed students. (2) Increased use of non-psychiatrist counselors.
>
> . . . develop Mental Health or Hygiene Center as part of our Health Services.
>
> Integrate the psychiatric service more closely with general medical staff.
>
> Increase the personnel and facilities so that fewer patients would have to be referred to other facilities for long-term therapy.

CONCLUSIONS AND RECOMMENDATIONS

Based on (1) a review of the available professional literature concerning the provisions for psychiatric services on a college campus, (2) authoritative recommendations containing specific guidelines for college psychiatric clinics, (3) the foregoing national survey of university psychiatric services, and (4) a review of the organizational and financial realities of university campuses, some conclusions may be drawn and resulting recommendations will be offered. These conclusions and recommendations will be outlined briefly without attempting extensive historical background or additional justification. It is believed that the recommendations are as accurate as available information permits, objective with reference to the problem area defined, and appropriate in terms of typical university settings.

Conclusions. The philosophy of higher education today is concerned with the total development of individuals which must include the mental health of students as well as the more traditional educational needs and physical well-being. While few institutions provide total physical and mental care for its student population, there is evidence that institutions recognize their responsibility to provide psychiatric consultation and evaluation for the benefit of the student, the institution, and the community.

Recommendations. The university must seek practical and realistic means to provide for at least a limited range of psychiatric services to the university community.

The need to provide at least a minimum of psychiatric evaluation and consultation is recognized. The professional literature and authoritative opinion have recommended that an institution with 20,000 enrollment, for example, should provide a separate psychiatric clinic staffed by five professional persons and two clerical employees. Including support services, this would amount to approximately $125,000 per year operating costs, exclusive of maintenance and overhead. If adequate funds could be provided and the professional staff obtained, the recommendation for a psychiatric clinic operating in conjunction with a Student Health Service would be most appropriate.

Recommendations for university psychiatric clinics would include the following:

1. Financial Support.
   a. Minimal: $4 per student per academic year.
   b. Optimal: $8 per student per academic year.
2. Staffing Ratios.
   a. Urban university with well-developed psychiatric facilities in area for referral; one full-time staff person for each 4,500 students.
   b. Non-urban university, with majority of students living away from home: one full-time person for each 2,000 students.
3. Administrative Organization.

   The clinic should be headed by a psychiatrist experienced in college psychiatric work. The use of a psychiatrist for occasional consultation is no substitute for the day-by-day supervision and guidance of a full-time psychiatrist-director.

4. Fee System.

A fee system is desirable for therapeutic reasons, but should not be heavily relied upon for income. It would seem desirable that from two to four hours be covered by the student health fee, and a small fee-for-service charged for interviews beyond that. It is important that income limits be imposed, so that the clinic will not be in competition with the private practice of psychiatry. The following chart suggests how such a fee schedule might be based on income.

Fee Scale
Rate Per Visit After Fourth Hour

Total Income Available Monthly*	Number in Family 1	2	3	4 or more
$100 or less	$3.00	$2.00	$1.50	$1.00
$100 to $150	$4.00	$3.00	$2.00	$1.00
$150 to $200	$6.00	$4.00	$3.00	$2.00
$200 to $250	$8.00	$6.00	$5.00	$4.00
$250 to $350	$10.00	$8.00	$6.00	$5.00
$350 and above	$12.00	$10.00	$8.00	$6.00

*Note: For students who receive room and board as part of a grant or scholarship, add $100 to the income for computing fee. Students whose parents have income exceeding $12,000, should usually be referred for private treatment.

5. Staffing Patterns and Budget.

a. For a university of 20,000, a staffing such as the following would seem desirable. This should provide services "a" through "g" as listed under the priority section which follows.

Position	Number	Salary
Psychiatrist-Director	1	$30,000
Staff Psychiatrists	2 @ $25,000 ea.	50,000
Clinical Psychologist	1	18,000
Psychiatric Social Worker	1	12,500
Receptionist-Secretary	1	4,500
Typist	1	3,700
Capital Outlay		5,000
Travel		500
Maintenance and Operation		1,600
Total Annual Budget		$125,800

b. Financial support as follows:

From student health fee ($3 per full-time student/sem.)	$105,000
Fees for service (see above Fee Scale)	20,800
Total Estimated Income	$125,800

c. With staffing as outlined above, the following direct clinical services could be provided:

Patients per year	1000 (minimum)
Clinical services	4800 patient-hours per year, consisting of:
Evaluation	2000 patient-hours
Psychotherapy	2000 patient-hours
Collateral Interviews	800 patient-hours

6. Priorities for Service.

With limitations of staff, it is suggested that the following activities be taken up, in sequence, as time, resources, and support become available:

a. Psychiatric consultation in case of emergency: suicidal or assaultive danger, acute psychosis, panic, etc.

b. Psychiatric consultation to all troubled students, with referral if therapy is necessary.

c. Complete psychiatric evaluation to those wanting and needing it; extension of supportive counseling and brief psychotherapy.

d. Institution of liaison-interpretive activities with administration and faculty.

e. Consultation service to interested campus agencies (i.e., academic guidance program, dormitory groups, etc.).

f. Modification of student attitudes by active education, through student paper, films, discussion series, etc.

g. Institution of a refined secondary prevention program: screening tests, sensitization of faculty and student personnel officers, dissemination of explicit criteria for referral, etc.

h. Expansion of clinical program to offer moderate-length definitive

psychotherapy and long-range supportive psychotherapy.

i. Establishment of ongoing, adequately financed research section.

j. Attempts at primary prevention, by participation in program-planning activities of administration.

k. Extension of clinical services to wives and children of students.

l. Extension of limited clinical services to faculty.

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PARTICIPANTS IN THE PSYCHIATRIC SURVEY

University of Alabama
The American University
Arizona State University
University of Arizona
University of Arkansas
Baylor University
University of California at Davis
University of California at Los Angeles
Clemson University
University of Connecticut
Cornell University
University of Denver
Florida State University
University of Florida
Georgia Tech University
University of Georgia
University of Hawaii
University of Idaho
University of Illinois
Iowa State University
University of Iowa
Kansas State University
University of Kansas
University of Kentucky
Louisiana State University
University of Maine
University of Maryland
Massachusetts Institute of Technology
University of Massachusetts
Miami University (Ohio)
Michigan State University
University of Michigan
University of Minnesota
University of Missouri
Montana State University
University of Nebraska
University of Nevada
University of New Hampshire
New Mexico State University
University of New Mexico
State University of New York at Buffalo
State University of New York at Stony Brook
North Carolina State University
University of North Carolina
North Dakota State University
Northern Arizona University
Northwestern University
University of Notre Dame
Ohio State University
Ohio University
Oklahoma State University
University of Oklahoma
Oregon State University
University of Oregon
Pennsylvania State University
University of Pennsylvania
Purdue University
University of Rhode Island
Rice University
Rutgers University
University of South Carolina
Stanford University
University of Tennessee
University of Texas at Arlington
University of Texas at Austin
Utah State University
University of Utah
University of Virginia
Washington State University
University of Washington
West Virginia University
University of Wisconsin at Madison
University of Wyoming

TEXAS TECH UNIVERSITY
Lubbock, Texas

PSYCHIATRIC SERVICES SURVEY

We are asking that you take a few minutes to complete this questionnaire as the administrator responsible for the psychiatric services on your campus.

Your responses to the following questions will provide us with both the numerical information concerning psychiatric services on your campus as well as some subjective impressions. PLEASE INCLUDE ONLY PSYCHIATRISTS IN YOUR RESPONSES--NOT PSYCHOLOGISTS, SOCIOLOGISTS OR OTHER PROFESSIONAL GROUPS.

1. Number of full-time equivalent psychiatrists on your staff _____
   Number of full-time psychiatrists on your staff _____
   Number of part-time psychiatrists on your staff _____

2. Do you utilize the services of psychiatric residents or interns?
   Yes _____ No _____ How many? _____

3. Approximate number of hours of psychiatric services available per week for:
   Consultation _____
   Evaluation _____
   Therapy _____
   Administrative Duties _____

4. Average salary for staff psychiatrists (12 month basis) $ _____

5. Salaries and operational costs for psychiatric services are financed through which of the following? (indicate fractional part, if possible)
   State Appropriations _____
   Tuition _____
   Student Fees _____
   Client Fees _____
   Governmental and/or Foundation Grants _____

6. On which departmental or divisional account are psychiatrists budgeted?
   _____

7. Organizationally, to which department or division are psychiatrists assigned?
   _____

8. Referrals for psychiatric services may be made by: (check all that apply)
   Self-referral _____
   Parents _____
   Faculty and Staff _____
   Administrators _____
   Residence Hall Staff _____
   Counseling Center _____
   Health Center _____
   Psychiatrists in private practice _____
   Community Agencies _____
   Other _____

9. Limits on term of therapy:
   No therapy provided _____
   Time limits (length of time) _____
   Session limits (number of sessions) _____
   No limits _____

(over)

10. Institutional records made of students who receive psychiatric help:
    Made a part of permanent health record _____
    Made a part of permanent personnel record _____
    No record made _____
    Other _____

11. As an institutional policy, does your central administration feel that it has a responsibility to provide psychiatric services? Yes _____ No _____

    To what extent?
    Primarily for evaluation or diagnosis _____
    Primarily for consultation and recommendations _____
    Primarily for therapy _____
    Complete evaluation and therapy _____

12. As the administrator of the psychiatric services program do you feel it is the university's responsibility to provide psychiatric services? Yes _____ No _____

    To what extent?
    Primarily for evaluation or diagnosis _____
    Primarily for consultation and recommendations _____
    Primarily for therapy _____
    Complete evaluation and therapy _____

13. Generally have you observed any reluctance on the part of students to accept psychiatric referral? Yes _____ No _____

14. How effective have the psychiatric services provided on campus been in aiding students with their problems?
    Great benefit _____
    Some benefit _____
    Little benefit _____
    Difficult to evaluate _____

15. If you were to offer a constructive suggestion for one change in your psychiatric services, what would it be? _____

_____

_____

_____ Check here if you desire the results of this study.

_____
Name

_____
University

_____
Address